Medical History Questionnaire

Name:	Today's Date://			
Birth Date://	Home Phone:			
Address:	Cell Phone:			
				Last Cua Evam.
Name of Medical Doctor:				
Traine of Medical Boolof.				Last Medical Exam://
D	D			
Do you wear glasses?				old is your present pair of lenses?
Do you wear contacts?		•		
Type of contact lenses: ☐ Rigid ☐ So	it u Exte	nded Wear	U Otner	Are they comfortable? ☐ yes ☐ no
Medical History				
Do you have any allergies to medications	? 🗅 no 🗆	□ yes If yo	es, explai	n:
List any medications you take (including	oral contrac	eptives, aspi	rin, over	the counter medications and home remedies):
		•		
-				
List all major injuries, surgeries and / or l	nospitalizati	ons you have	e had:	Additional desired and the second sec
				ng eyelid, prominent eyes, glaucoma, retinal disease, cataracts,
eye infections or eye injury:				
The state of the s				
Family History Places note any family history (parants of	randnarante	ciblings ch	ildron: li	ring or deceased) for the following conditions:
DISEASE / CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	0	<u>o</u>		
Cataract	0	ū	٦	
Crossed Eyes	ū		0	
Glaucoma	0	<u> </u>		
Macular Degeneration				
Retinal Detachment/Disease		۵		Annual Control of the
Arthritis		٥		Marie
Cancer		0		
Diabetes				
Heart Disease		a		
High Blood Pressure				
Kidney Disease				
Lupus				
Thyroid Disease		ū		
Other				

Social History	This information is ke	ept strict er to dis	tly confident scuss my So	<i>ial. Ho</i> v ocial Hi	vever, you may discuss this portion directly with the story information directly with my doctor (check	doctor i	if you pref	er.			
Do you drive? ☐ no		If yes, do you have visual difficulty when driving? \square no \square yes If yes, please describe:									
Do you use tobacco pro	ducts? 🗆 no 🗅	yes	If yes, type	e/amou	int/how long:			_			
Do you drink alcohol?	🔾 no 🔾	l yes	If yes, type	e/amou	int/how long:						
•		-	If you turn	a/amou	int/how long:						
Do you use illegal drug		•			_		-				
Have you ever been exp	osed to or infected wi	th: 👊	Hepatitis	U HI	v usm						
Gender assig	ned at birth: 🗖 Fema	ale 💷 l	Male.								
Are You pre	gnant or nursing?	Yes □	No 🗆 N	I/A							
Review of Sys	tems										
Do you currently, or ha	ve you ever had any p	roblems	s in the foll	owing	areas:						
SYSTEM		NO	YES	?		NO	YES	?			
CONSTITUTIONAL		110	1130	•	EAR, NOSE, MOUTH, THROAT	•					
	ght Loss Gain				Allergies/Hay Fever		ū				
INTEGUMENTARY	-				Sinus Congestion						
NEUROLOGICAL					Runny Nose						
Headaches					Post-Nasal Drip						
Migraines					Chronic Cough		<u> </u>	<u> </u>			
Seizures					Dry Throat/Mouth						
EYES	_	_		_	RESPIRATORY			_			
Loss of Vi		0	Ö		Asthma	0		0			
Blurred Vi		0	0		Chronic Bronchitis						
	/ision/Halos		0		Emphysema VASCULAR / CARDIOVASCULAR	_	_	_			
Loss of Sid Double Vi				o o	Diabetes	`	۵	۵			
	sion	0	0		Heart Pain	<u> </u>	<u> </u>	٥			
Dryness Mucous D	ischarge	_	<u> </u>	0	High Blood Pressure	ā	<u> </u>	ā			
Redness	ischarge	0	<u>-</u>	ū	Vascular Disease	ā	<u> </u>				
	Britty Feeling	ā	ā	<u> </u>	GASTROINTESTINAL						
Itching	rand a coming	ū	ā	ū	Diarrhea						
Burning					Constipation						
•	ody Sensation				GENITOURINARY						
Excess Tea	aring/Watering				Genitals/Kidney/Bladder						
Glare/Ligh	t Sensitivity				BONES / JOINTS / MUSCLES						
Eye Pain o					Rheumatoid Arthritis	<u> </u>	<u> </u>	<u> </u>			
	fection of Eye or Lid				Muscle Pain	Ö	0				
Sties or Ch			<u> </u>		Joint Pain						
	oaters in Vision		Ō		LYMPHATIC / HEMATOLOGIC		_	_			
Tired Eyes					Anemia		٥				
ENDOCRINE	shan Clauda		0	0	Bleeding Problems ALLERGIC / IMMUNOLOGIC	u	_				
i nyroid/O	ther Glands		.	_	PSYCHIATRIC		۵				
If you answered YES	to any of the above o	r have	a condition	n not l	isted, please explain and list medications:						
							10				
